Investigating a failed policy: the French state and medical demography (1960-2015)

Enquête sur une politique manquée. L'État français et la démographie médicale (1960-2015)

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Abstract

France has never had as many doctors as today. However, the French healthcare system is characterized by a very unequal distribution of healthcare provision, so that access to medical care becomes more difficult for growing sections of the population. This situation is all the more surprising given that, since the 1970s, the French state has equipped itself with instruments supposed to regulate the number of doctors practicing in France, both in terms of their overall workforce and their distribution between disciplines. In addition, since the 2000s, the public authorities have stepped up measures to encourage a better geographical distribution of doctors. To understand the failure of these measures, this article examines the social and political logics that have been predominant in their adoption and implementation. Based mainly on administrative records, it describes how the French state, in close relationship with the medical profession, defined the problem of medical demography from the early 1960s onwards, and what successive responses it has given it without succeeding in solving it.

Keywords: Medical Demography; Doctors; Healthcare Inequalities; State; Public Policy.

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Résumé

La France n'a jamais autant compté de médecins qu'aujourd'hui. Pourtant, le système de santé français se caractérise par une répartition très inégale de l'offre de soins, si bien que l'accès aux soins médicaux devient plus difficile pour des fractions croissantes de la population. Cette situation apparaît d'autant plus surprenante qu'à partir des années 1970, quand l'État français s'est doté d'instruments supposés réguler le nombre de médecins exerçant en France, tant au niveau de leur effectif global que de leur répartition entre disciplines. En outre, à partir des années 2000, les pouvoirs publics ont multiplié les mesures visant à favoriser une meilleure répartition géographique des médecins. Pour comprendre l'échec de ces mesures, cet article étudie les logiques sociales et politiques qui ont été prédominantes dans leur adoption et leur mise en œuvre. S'appuyant principalement sur des archives administratives, il décrit comment l'État français, en relation étroite avec le corps médical, a défini le problème de la démographie médicale à partir du début des années 1960, et quelles réponses successives il lui a apportées sans parvenir à le résoudre.
Mots-clés : Démographie Médicale; Médecins; Inégalités d'Accès aux Soins; Etat; Action Publique.

Introduction

By 2015, France had almost 217,000 doctors. Not only has the number of practicing doctors in France never been so high, but also the medical density itself has never been greater. Also in 2015, there were only 338 doctors per 100,000 inhabitants, compared with 329 in 2000 and 194 in 1980. However, these data conceal significant disparities and contrasting developments according to the modalities and areas of practice of physicians. Since the mid-2000s, the number of general practitioners has stagnated, and even declined in many parts of the territory, while the population has continued to increase. In hospitals, thousands of job positions are not filled. These difficulties do not refer only to rural areas. In large cities, which concentrate a larger proportion of physicians, the time required to get a consultation with certain categories of specialists is increasingly long. This development, combined with the explosion of the number of fees charged by the liberal medical practitioners, causes patients to give up some types of care, or leave them for later.

However, since the early 1970s and 1980s, the French state has developed instruments to regulate the number of doctors working in the country, both in terms of its general workforce and its distribution between disciplines (general medicine and specialties). Moreover, since the early 2000s, governments have multiplied measures to promote better geographical distribution of physicians. Nevertheless, none of these measures provided a satisfactory answer to the problem of unequal distribution of medical care. In order to understand this failure in relation to the declared objectives of these measures, it is necessary to reconstruct the prevailing social and political logics in their adoption and implementation. To do this, I conducted a historical survey of how the "problem" of medical demography in France has been settled since the early 1960s, and how the French state, in close connection with certain segments of the medical community, has intervened in this area. This research, which is mainly based on administrative records and

other documentary sources,[1] showed that the issue of medical demography has been the subject of recurring struggles not only in the medical community but also within the state. For various reasons, related mainly to the position they occupy within the medical field, physicians have been often divided over this subject. These debates have also occurred at the administrative and political levels, and medical demographics have drawn the attention of ministerial departments with divergent concerns and interests. Thus the way governments have addressed the issue of medical demography has been the result of numerous compromises between these actors. In the decisions made on the subject, the medical needs of the population have always been strategically defined and mobilized, and the consideration of these needs has always been subordinated to the interests of the parties involved.

In doing so, this research aimed not only to illuminate the tensions that currently cross the French healthcare system, but also to show the limits of certain studies carried out in the sociology of the professions on the so-called processes of "professional closure", that is, on the strategies and mechanisms that limit access to a particular profession and reduce competition among its members. This body of research, inspired by Weberian sociology on "closed economic groups" (Weber, 1995), often grants excessive unity to professional groups and underestimates the importance of specific logics of the political and administrative field (Le Bianic, 2008). We will return to this issue to conclude.

This article follows a chronological order. As a first step, I will concentrate on the genesis of the *numerus clausus* of medicine, which is the oldest and most important instrument ever created to regulate the medical workforce in France. So I will show how the *numerus clausus* was supplemented by other quotas, on access to specialized training and trained doctors from countries outside the European Union. Next, I will analyze how all these quotas were implemented in the 1980s and 1990s, in a logic mainly focused on controlling the costs of health insurance, preserving the economic interests of independent doctors (*médecins libéraux* in French). As a final step, I will describe the difficulties that this policy entailed and the changes it underwent in the 2000s, even though the difficulties related to the inequal distribution of care provision have not been resolved yet.

Instituting the *numerus clausus* of medicine

Until 1971, future physicians were selected by exams, as in other university courses. On the one hand, the cost and length of medical education, and the economic risks associated with the private practice of medicine on the other, at a time when the salaried positions of professionals were still rare, both have had the effect of limiting the number of candidates. In the 1950s, the number of medical students stagnated, while the total number of students enrolled in French universities increased by more than 40%. Just over 2,000 state doctor degrees were issued each year.

However, in 1960, the number of medical students increased sharply: from 31,500 in 1960 to 54,700 in 1966, a growth of 74% in six years. Although this phenomenon was found in other academic disciplines and has been favored by very general factors, such as the increase in the number of university students and the mitigation of class and sex social discrimination in higher education, it was also due to specific factors. On the one hand, the generalization of contract medicine (*médecine conventionnée*) after the promulgation of the "Bacon Decree" of May 12, 1960, made the independent practice of medicine economically safer (Hatzfeld, 1963).[2] On the other hand, the 1960s were marked

1 I refer here to my book for a detailed list of sources (Déplaude, 2015). This article is a very concise presentation of the contents of this book.

2 Physicians under contract with the French Social Security agreed to respect the rates set by it, in exchange for having about 80% of the expenses incurred by patients (fees and revenues) reimbursed. The generalization of contract medicine resulted in making independent practitioners accessible to the majority of the population and thus encouraging a rapid increase in demand for care.

by an unprecedented expansion of hospitals and important therapeutic and technical advances that enhanced the prestige of the medical profession. This was favored by the state, including the adoption of the so-called "Debré" reforms of 1958, which created "hospital and university centers" (CHUs), and hospital financing that encouraged their development (Chevandier, 2009, Jamous 1969). Correspondingly, many salaried medical positions were created in hospitals, including the most coveted ones, the "medical teachers", who combined salaries from the university and from the hospital.

In the beginning, the increase in the number of medical students was not seen as a problem: both at the state level and at the medical community, the idea that many doctors needed to be trained was widely shared - the French healthcare system was even considered to lay behind those of other industrialized countries. This was true for doctors in hospitals and universities, for whom training more doctors was crucial for the development of CHUs, and for an organization such as the Confederation of French Medical Unions (CSMF, *Confédération des syndicats médicaux français*), then dominant among independent doctors: for it, it was a matter of answering the problem of the "excessive workload" of independent doctors (and especially of general practitioners) in the face of very rapid growth in the demand for care. For the CSMF, an excessive workload would certainly result in higher incomes, but also in a deterioration in the conditions of practice, at the risk of making the medical profession less attractive to students.

The social and political crisis of May-June 1968, marked by major student mobilizations and strikes in virtually all sectors of the French economy and administration, changed the game. This crisis spared neither hospitals nor medical schools, where strikes took place, occupations and many scenes that symbolically reversed the very marked hierarchies of the teaching hospitals. Some doctors from teaching hospitals, especially the Parisians, came together to claim a "selection" in admission to medical schools. In fact, they feared that the rapid increase in the number of students would result in a lasting depreciation of the practice of medicine. They received the support of the French Order of Physicians (*Conseil national de l'Ordre des médecins*) and of the most conservative organizations of independent medicine, such as the Federation of Physicians of France (*Fédération des médecins de France*), which claimed total freedom in fixing the medical fees (Déplaude, 2009a, 2009c). They also received significant state-level support from the Ministry of Budget, concerned about the rapid increase in health spending, which went from 3.5% to 5% of the Gross Domestic Product between 1960 and 1970 (Caussat, Fenina; Geoffroy, 2003). For this ministry, it was essential to control the number of physicians in order to control the development of public health spending over the long term. Indeed, in France, all individuals who hold a state diploma in medicine and are registered by the Order of Physicians (which is, for holders of a state diploma, a mere formality) may request to contract with the French Social Security. The latter cannot refuse it, regardless of where physicians decide to settle and the specialty they choose to pursue. Due to the almost automatic agreement of the independent doctors by the Social Security, the graduation of a greater number of practitioners was therefore likely to result in additional costs for public health insurance.

To justify the introduction of an entrance exam at the beginning of medical studies, advocates of the "selection" used a powerful argument: that it was necessary to ensure the quality practical training for future physicians. In fact, until 1968, students did not receive the same clinical training: the "externs", who were selected through exams organized by hospitals from their second year of medical studies, received a much more intensive practical training than the other students, who were not as well thought of by hospital doctors. However, in response to a demand expressed by medical students mobilized in May 1968, the government removed the exams that selected externs, so that all students received the same practical training. Thus, the problem was to assign hospital functions to all students, in a context in which many hospitals were under construction or renovation. The main argument of selection advocates was therefore that the number of medical students should be proportional to the training capacities of hospitals.

Despite the reluctance of some government officials, who feared a new "May 1968" more than anything else, a law established in 1971 a "limitation" to the number of students received in the second year of medical education, according to the training capacity of hospitals. The French government, which was careful and concerned not to be accused of Malthusianism, chose to stabilize the number of students received from the first year of medical studies, without reduction. In 1979, the principle of entrance exam was no longer disputed, and the government introduced a new criterion in determining the *numerus clausus*: "the population's health needs". In fact, no one knew how to determine such needs and deduce the number of doctors in training. However, this notion was a convenient fiction that allowed governments to more freely determine the *numerus clausus* – and especially to reduce it – without being linked to the evaluation of the training capacity of hospitals, which was made by teaching hospital physicians (Déplaude, 2009b).

A system of quotas

Debates over medical demography after the events of May-June 1968 were not only about the number of students to be admitted to the second year of medical studies but also about access to specialized training. In fact, a growing proportion of medical students chose to study in a specialty (ophthalmology, cardiology, pediatrics, dermatology, etc.) and moved away from general medicine. In fact, with the exception of surgery, it was possible to graduate in a specialty without having passed the "residence" entrance exam (*concours de l'internat*), organized by hospitals from the fourth year of studies, providing access to remuneration and hospital responsibilities.[3] Since 1947, governments authorized the creation of "certificates of special studies" (*certificats d'études spéciales*) issued by medical schools. Less prestigious and selective than the "royal" CHU residency, they did not provide access to hospital and academic careers, but they allowed the establishment as a specialist in the private sector. These courses were very popular among students, half of whom enrolled after earning their doctorate in medicine in the mid-1970s.

This trend was denounced by the unions of independent doctors, that feared that the development of specialized medicine would reduce the scope of general practitioners' practice and devalue their profession. The shortage of vacancies opened in hospitals also meant that a growing share of former CHU residents practiced in the private sector where they faced competition from specialized doctors issued from courses that were considered as less selective and less formative. The government, in turn, sought to curb the development of specialized medicine, which was considered more expensive for the public health insurance than general medicine. In addition, it had to comply with European directives (adopted in 1975) on the training of physicians, which provided that all students wishing to graduate in a specialty would hold hospital responsibilities. At the end of discussions and negotiations that spanned more than fifteen years, access to specialized training was limited by a reform of medical studies in 1982: from that moment on, only the ones approved in the residence entrance exam could graduate in a specialty. CHU physicians required that future specialists be trained primarily in their services, to the detriment of non-university hospitals that employed many students preparing for a certificate of special studies. In addition to improving the training of specialists, one of the main goals of the reform was to reduce the number of trained specialists by reducing the proportion of students training in a specialty to one-third. However, contrary to their original intent, governments have not succeeded in imposing quotas by specialty, except for psychiatry, biology and public health, which represented only a small proportion of trained specialists. Medical students and doctors at university hospitals actually succeeded in ensuring that the medical residency established by the 1982 reform remained as close as possible to the former residence of university

3 The most selective and sought after residence entrance exams were those organized by the CHUs – and particularly those from Paris. In the 1960s, only 15% of medical students achieved the CHU residence (Laugier; Gout, 1962).

hospitals, liberal and elitist; the students wanted to keep the choice of specialization as free as possible, and the doctors wanted to continue to be able to recruit residents based on the needs of their services in any particular specialty.

Finally, the institution of quotas restricting access to the second year of medical school (the *numerus clausus* itself) and then those regulating the access to specialized training (the new residence entrance exam) were accompanied by measures aimed at regulating the installation in France of doctors trained abroad. Since 1892, it was necessary to hold the state diploma of doctor of medicine to practice in France. In 1933, as a result of xenophobic mobilizations, a law also introduced a condition of French citizenship (Evleth, 1995). Given these draconian conditions, very few professionals trained abroad had the right to work in France. However, in 1972, a law authorized the issuance of work permits for doctors who did not meet these conditions, subject to an assessment of their diplomas and their careers by a specialized committee. The first "work licenses" issued mainly benefitted doctors who had emigrated to France for political reasons. However, members of the Commission, composed of representatives of the medical community and the state, very quickly came to the agreement that the number of work licenses issued per year should not exceed 1% of the *numerus clausus*, especially for fear of provoking xenophobic reactions among medical students (Déplaude, 2011).

Thus, in the early 1980s, a complete system of quotas linked to each other regulated the access to the practice of medicine in France. Thanks to these quotas, the public authorities theoretically had the power to determine the number of doctors who could practice in France and their distribution between general practice and specialties.

Rationing the number of doctors

Until the early 2000s, the determination of quotas that restricted access to the medical profession was the subject of recurring struggles, both within the medical community and the state. It opposed mainly the unions of independent physicians to the representatives of medical teachers. From the mid-1970s to the mid-1990s, the former were constantly calling for a reduction of the quotas – and, firstly, of the *numerus clausus* of medicine. In fact, the labor market in this period was marked by the flow of great promotions of doctors trained in the late 1960s: the number of physicians in practice rose from 81,000 in 1975 to 173,000 in 1990. With the insufficient number of vacancies created for salaried doctors, the great majority of young doctors established themselves as independent professionals. The difficulties were concentrated in the general practitioners, more numerous, competing with medical specialists and generally applying, unlike the latter, Social Security fees:[4] not only did the professionals settling in the 1980s take longer than their predecessors to build their clientele, but they could not, even after several years, achieve a similar level of income (Beudaert, 1999). Within unions of independent physicians, representatives of general practitioners also advocated for a drastic reduction in the number of physicians graduated in universities. Moreover, the fragmentation of unions of independent physicians, involved in fierce competition to represent the interests of independent physicians (Hassenteufel, 1997), led them to radicalize their positions on the subject.

On the other hand, teaching doctors were concerned about the consequences of reducing the number of doctors in training on medical schools and especially on the operation of hospital services. Indeed, creations and renewals of vacancies for doctors in teaching hospitals partly depended on the number of students enrolled in medical schools: the reduction in their number – from 148,500 in 1978 to 113,700 in 1988 – made it difficult to obtain these teaching positions. This was so worrying as the inequalities in staffing among institutions were glaring. But, above all, a *numerus clausus* could translate into a long-term decrease in the number of residents, *i.e.* the number of trained specialists in hospitals. Medical residents were

4 In 1980, the government allowed doctors to charge higher rates than those of the Social Security. Unlike specialists, very few general practitioners opted for this possibility, some out of conviction, others out of fear of losing patients.

indispensable for the operation of many hospital services as they assumed a large part of shifts and took on numerous other tasks. In principle, the decrease in the number of residents should have been compensated with the creation of vacancies for hospital physicians, but the significantly higher cost of such positions and the difficulty in recruiting professionals who were willing to work in shifts have made the maintenance of a sufficient number of residents a major challenge for hospitals and universities. Consequently, although some of them supported the institution of the *numerus clausus*, from the 1980s they strongly opposed to a sharp decline in that number.

These internal struggles in the medical community were redoubled within the state by an opposition between two sets of administrations. On the one hand, public health insurance managers - who represented the administrations in charge of the state budget and of the Social Security - strove above all to contain the increase in public health expenses, which had become a major concern of the government in the 1970s (Pierru, 2007). For these high officials, medical demography represented an important issue for the control of health expenses, since they defended the idea that the existence of many physicians - and particularly specialists - generated an artificial demand for care and, thus, unnecessarily increased the costs of health insurance (Déplaude, 2010). In 1996, the Ministry of the Budget would still defend the idea that the *numerus clausus* should not only be a management tool (health expenditure control), but also a reform tool. According to this ministry, it was a matter of putting the healthcare system under pressure (possibly at the price of a shortage of professionals in some areas) to encourage doctors to accept, or even want, some unpopular measures: closure of hospital services, restrictions on freedom of installation of independent doctors etc. Becoming more efficient, the health system would allow the French to be cared as well as or better than before, with fewer doctors.

On the other hand, the Ministry of Education and then the Ministry of Health relayed the concerns of teaching doctors: they were mainly concerned with the consequences of reducing the number of doctors in training in hospital services. They were able, along with the teaching doctors, to make the *numerus clausus* be distributed over time; but they could not avoid a sharp decline in this quota, according to what unions of independent doctors and health insurance managers demanded: from 7,900 in 1979, the *numerus clausus* decreased to 3,500 in 1993, and it maintained that level until the end of the 1990s. The number of vacancies advertised in residence examinations decreased, however in a less marked way so as not to create too many difficulties for hospital services. It was reduced by about one-third, and as a result, the goal of reforming medical studies in 1982 - to train fewer specialists and more general practitioners - was not achieved. It was the opposite that happened: since 1998, France has trained more specialists than general practitioners.[5]

Ultimately, during the years 1980-1990, the quotas regulating access to the medical profession were not based on a rough estimate of the "health needs" of the population. The concern of governments to contain the increase in public health expenditure on the one hand and to minimize the consequences of reducing the number of doctors in training on the operation of hospital services represented much more decisive issues.

A still unequal healthcare system

The policy pursued by the government on the issue of medical demography between the late 1970s and the late 1990s has had positive effects for many physicians, particularly independent doctors. The early career of young general practitioners is much less difficult today than it was in the early 1980s. The sharp drop in the number of doctors trained at universities has also helped unions of independent practitioners to successfully defend the almost automatic contracting of professionals

5 In addition, among general practitioners, many are turning to a specialized practice (Allergology, Sophrology, Acupuncture, Emergency Medicine, Occupational Medicine, School Medicine, etc.) without even having the specialist title after their studies. Today, among physicians licensed in general practice, one-third do not practice it specifically (ONDPS, 2008).

by the Social Security, to which the health insurance managers have tried to put an end to. However, the reform of medical studies in 1982 and the adjustment of quotas were at the origin of significant difficulties for hospitals. Initially, these difficulties were concentrated at the level of non-university hospitals, which had lost many trained specialists for CHU's benefit, and lacked doctors to ensure the operation of services. Faced with these difficulties, which have also affected the CHUs since the 1990s, hospitals have hired physicians trained outside the European Union: indeed, although not authorized to practice as independent physicians, these doctors could be employed in hospitals under special statutes, precarious and poorly paid. After initially facilitating recruitment, the French government tried to limit them, but in vain. Today, doctors with non-EU diplomas contribute to a very important part of the functioning of French hospitals; few of them work as independent practitioners.

However, in addition to the hospital sector, the predicted decrease in the number of physicians, due to the *numerus clausus*, have begun to worry the Order of Physicians and some unions of specialists in the 1990s. Far from being homogeneous, the decrease in the number of physicians would affect more particularly certain specialties and geographical areas in which physicians were already scarce. Fearing this prospect, likely to lead to a deterioration in the working conditions of many physicians and to increasing difficulties of access to care in certain parts of the territory, they called for more doctors to be trained, particularly in certain specialties. Some politicians, often based in rural areas, were also interested in the issue of medical demography and called for measures to enable doctors to establish themselves in their territories.

These claims, supported by the demographic projections of the Ministry of Health, have been widely disseminated since 2001. The government, which had begun to loosen the *numerus clausus*, increased it dramatically from that date - from 3,600 in 1997 to 7,000 in 2006 -, and it stabilized at that level. Likewise, the number of residence vacancies offered has increased. To date, the increase in quotas has been the main response of the authorities to the problem of medical demography, as it has been redefined since the late 1990s. We can analyze this increase as a policy of "supply saturation", which consists to train many physicians in the hope that a sufficient number of them will practice in less attractive places (Bourgueil, 2007).

However, the state has also taken many measures to encourage the installation of young graduates in areas with poor medical care. Contrary to what some actors wanted (politicians from rural areas, public health insurance managers and representatives of the hospital community), these measures did not limit the freedom of establishment of the independent physicians, making the Social Security agreement conditional on the choice of place of establishment, as it has been done in several paramedical professions since 2007.[6] To date, no government has dared to confront the unions of independent doctors and, even more, the student and resident unions, questioning the doctors' almost automatic agreement by the Social Security. The measures adopted by the public authorities have exclusively consisted of positive incentives, mainly financial, for the establishment in areas lacking physicians (material aid for establishment, increased fees for the practice in needy areas, "public service commitment contracts", "territory's general practitioners'" provisions). Despite their cost to public finances, these measures have had very weak effects so far. In addition, they have been focused on general practitioners, while liberal specialists are distributed even more unevenly in the territory.[7] The maintenance of the almost automatic agreement of the independent doctors by the Social Security and, therefore, the weak regulation of the establishment of professionals in the independent

6 One such measure would be, for example, to deny that doctors wishing to settle in areas already well-equipped with doctors can contract with the national Social Security.

7 Even without considering the Paris region (which represents an atypical case because of the size of Parisian hospitals), regional differences in medical density range from 1 to 1.4 for general practice and from 1 to 1.6 for specialties (Conseil National de l'Ordre des Médecins, 2016). The differences are even more striking at the subregional level.

sector, have had two important consequences. First, they encourage the perpetuation of a very unequal geographical distribution of physicians in the territory, both among general practitioners and among specialists. They also contribute to hospital recruitment difficulties, since many young specialists, considering hospital care insufficiently attractive, prefer to establish themselves as independent professionals, with predominantly higher fees than those of the Social Security.[8]

Although the doctors' tendency to establish themselves preferentially in large cities where there are more economic opportunities, and where professional communities are the most developed, is not a new phenomenon (Tonnelier, 1992), it is reinforced today by two simultaneous changes. On the one hand, most doctors' spouses today have a professional activity and most often hold highly qualified positions. This requires finding a place of exercise that allows the spouse to find a satisfactory job, which favors the establishment in large cities, where employment opportunities with a high level of qualification are the highest. On the other hand, the fact that physicians most often have an active spouse has led an increasing number of them to find an activity mode compatible with some investment in the domestic sphere: the "permanent availability" model, characterized by a strong amplitude of hours of work, is declining even among men (Lapeyre, Le Feuvre, 2005). However, the practice of medicine in areas with few physicians continues to present stronger constraints, particularly from the point of view of working time, the volume of shifts to take on and greater challenges for the physician replacement. As a consequence, candidates for these regions are rare, and many retiring doctors are not replaced.

Final considerations

Contrary to analyses that are still common in the sociology of professions and studies devoted to the history of the medical profession, our study shows that French physicians did not always defend Malthusian positions on the issue of medical demography, and were seldom united about it. Whereas the research on the sociology of professions has emphasized professional closure processes, i.e. quota strategies for a particular profession to contain its recruitment and preserve its economic and symbolic interests (Larson, 1977; Paradeise, 1988), we have demonstrated that it has not always been the case. For various reasons, related to the position they occupied in the field of medicine, doctors have been divided on this subject. In addition, the preservation of the economic and symbolic interests of physicians did not always imply a strict limitation on the number of professionals, including in the eyes of the representatives of independent doctors. In certain circumstances – which are not uncommon considering the last fifty years – they believed the opposite, that it was by increasing the number of doctors that these interests would be better defended. Being more numerous, physicians could meet the demands of their patients by maintaining acceptable working condition and they would also be more powerful. The demographic decline of a professional group is not always advantageous for its members: it can lead to a narrowing of its jurisdiction, and thus to a weakening of its social position, whether it is a simple segment within the medical community or the profession as a whole.

Moreover, not only the economic and symbolic logics to which closure theories attach great importance can lead to the opening or closing of a group, but they are not the only ones having a role in professional demography. First, the logic of representation has specific effects on the positions of the medical community's spokespersons. For example, the fragmentation of the unions of independent doctors in the 1980s and the competition between these organizations led them to "shoot at the stars" and dramatize the problem of medical demography. Second, institutional logic has weighed heavily on the way doctors in teaching hospitals became apprehensive about the issue of medical demography. The dependence of hospital and university institutions on the flow of physicians in training largely explained the positions taken by

8 In 2016, more than 60% of surgeons, dermatologists, obstetricians, pediatricians, psychiatrists and gastroenterologists charge higher fees than the Social Security (CNAM, 2017).

their representatives, both in terms of pedagogy and medical demography, over the past fifty years.

From the 1960s to today, medical demography has therefore been a matter of struggles within the medical profession. These struggles have been largely carried out within the state, for which health is a major area of public action. With different prerogatives, many ministerial departments have been interested, with the national health insurance, in medical demography since the early 1960s. However, these actors have often held opposing views on the policy to be led. The internal struggles within the medical profession on the issue of medical demography were often redoubled by struggles within the state. These touched on major social and political issues such as access to higher education, the quality of training offered to future doctors, the selection of medical elites, the operation of hospitals or the medicalization of the territory. This explains that although medical demography has rarely been a subject of partisan confrontation, decisions on this subject have often obeyed a strictly political logic involving top political leaders. In many cases, these decisions have been made less on the basis of an assessment of the population's health needs, which were difficult to implement, and more on a pragmatic assessment of their short-term political costs or benefits. Decisions taken on medical demography have generally obeyed the interests of the most powerful segments of the medical community. Given that the latter come mainly from the richest and most medicalized areas of the country, the territorial inequalities in the provision of care are likely to continue.

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